Pertzye®
(pancrelipase)
Delayed-Release Capsules

UNINSURED Patient Assistance Program℠

This program is available for patients with financial difficulties. Physicians apply for this program on behalf of their patients. Eligibility is determined on a case-by-case basis through a formal review process at Lumicera Health Services. Upon approval, a FREE three month supply of Pertzye® will be sent to the patient. Patient is eligible for three 90-day refills. Patients must re-enroll for the assistance program once per year.

Eligibility: Through the Pertzye® Uninsured Patient Assistance Program℠, patients who experience financial difficulties may be able to receive Pertzye at no cost. To be eligible, a patient must:

1. Have a valid prescription for Pertzye with an approved indication for a 90 day supply, with 3 refills
2. Be a legal US resident
3. Not have any commercial insurance coverage for Pertzye
4. Not be insured by any government programs (e.g Medicare, Medicaid, Tricare)
5. Have an annual household income not to exceed 500% of the federal poverty level

To apply for this program, complete the enrollment form on the reverse side.

DCI Digestive Care, Inc.
1120 Win Drive, Bethlehem, PA 18017-7059
Voice: 1-877-882-5950 | **Fax:** 610-882-0349 | **www.pertzye.com**

23026 | 09/2023

Pertzye® (pancrelipase) Delayed-Release Capsules Containing Bicarbonate-Buffered Enteric-Coated Microspheres

Date of Request: _ _ - _ _ - _ _ _ _
Month Day Year

Uninsured Patient Assistance Program℠ Enrollment Form

Fax this Enrollment Form to Lumicera Health Services at: 877-885-1103

PRESCRIBER AND PRESCRIPTION INFORMATION (to be completed by prescriber):

Physician Name:

Center Name: Phone #:

Center Address: Fax #:

City: State: Zip Code:

Physician Email:

Product Requested: ☐ **Pertzye® 4,000** ☐ **Pertzye® 8,000** ☐ **Pertzye® 16,000** ☐ **Pertzye® 24,000**

Capsules per Day: Capsules per Meal: Capsules per Snack:

Quantity (3 month supply required): Refills (3): Diagnosis Code:

Sig:

Physician Signature: NPI/DEA #:

PATIENT INFORMATION

Patient Name:

Date of Birth: - - Patient's Age: Gender: Weight: Height:

Address (No PO Box):

Phone Number:

Allergies: Medications:

Do you have commercial insurance? Yes ☐ No ☐

Do you have any federally funded insurance plan such as Medicare, Medicaid, or Tricare? Yes ☐ No ☐

Number of people in your household: Annual Household Income (You may be required to show proof of income):

Insurance Information:

RX BIN RX PCN RX GROUP RX ID#

Reason for Request:

Consent and Authorization Agreement

I hereby authorize Lumicera Health Services to enroll the above-named patient in the Pertzye® Uninsured Assistance Program℠. I understand the enrollment in the Pertzye® Uninsured Assistance Program℠ may qualify the patient to receive a three month supply of Pertzye® free of charge. The Pertzye® Uninsured Assistance Program℠ is subject to availability of products and does not constitute an entitlement. If approved for PAP, I affirm and acknowledge that I will immediately notify Lumicera Health Services of any change in my financial status and/or insurance coverage changes by calling 877-885-1101. I will not seek reimbursement of any type from any providers for any costs of the medications received.

Patient Name (please print) Patient Signature:

IF PATIENT IS A MINOR:

Parent/Guardian/Guarantor Name (please print):

Parent/Guardian/Guarantor Name Signature: Date:

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